MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6831 Reg. Dist. No. 06785

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East
c. LENGTH OF STAY IN 1b Visiting
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pa b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essington 75X 3
d. STREET ADDRESS 213 Taylor Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Sonya Middle Annette Last Achey
4. DATE OF DEATH Month 6 Day 18 Year 19 60
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1-31-1940
9. AGE (In years last birthday) 20 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Student
10b. KIND OF BUSINESS OR INDUSTRY Student
11. BIRTHPLACE (State or foreign country) Pennys
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William F. Achey
14. MOTHER'S MAIDEN NAME Rita May Schwartz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -----
17. INFORMANT Address Essington, Pa. William F. Achey, 213 Taylor Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned in North East River — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trying to turn over capsized boat
20c. TIME OF INJURY Hour 3.30 a. m. Month, Day, Year 6 18 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East River
20f. (City or town) North East (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R.C. Dodson M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 6-20-60
EXAMINER'S NAME (Type) R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6-23-60
22c. NAME OF CEMETERY OR CREMATORY Schuykill Memorial
22d. LOCATION (City, town, or county) (State) Schuykill Haven Penna

23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS Joseph R. Grant North East, Maryland
24a. REC'D BY REGISTRAR DATE JUN 22 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6832

CERTIFICATE OF DEATH

Reg. Dist. No. 06787

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH EAST RURAL
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH EAST RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: MARGARET — Middle: JANE — Last: CARPENTER

4. DATE OF DEATH — Month: 6/ — Day: 26/ — Year: 1960

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/ 27/ 1960

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months 1, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: KENNETH CARPENTER

14. MOTHER'S MAIDEN NAME: REBECCA BENJAMIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

INFORMANT: KENNETH CARPENTER — Address: NORTH EAST, MD. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastroenteritis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

764.0

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ________, 19___, to ________, 19___, that I last saw the deceased alive on ________, 19___, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 6/27/60

PHYSICIAN'S NAME (Type): Neil Taylor Jr — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/29/ 1960

22c. NAME OF CEMETERY OR CREMATORY: HOPEWELL CEM.

22d. LOCATION (City, town, or county): PORT DEPOSIT (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen — ADDRESS: RISING SUN, MD.

24a. REC'D BY REGISTRAR DATE JUN 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Mrs 206523 3XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6816 — Reg. Dist. No. 06788

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City,
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle R. — Last CRAWFORD
4. DATE OF DEATH: Month June — Day 9, — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 10, 1902
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: Accountant
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No information
14. MOTHER'S MAIDEN NAME: No information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 084-01-7085
17. INFORMANT: Mrs. Beatrice Crawford, Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): R. C. Dodson, M. D. — June 9, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: St. Augustine Cem.
22d. LOCATION (City, town, or county) (State): nr. Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR: JUN 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. ATSME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06789
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil 6833 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Port Deposit
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace, R.D.1 12X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle [redacted] Last Crigger
4. DATE OF DEATH: Month 6 Day 20 Year 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: [redacted] 5/12/15
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Auto.
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Add Crigger
14. MOTHER'S MAIDEN NAME: [redacted] Hyle Hensley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-18-4080
17. INFORMANT: George C. Crigger, Havre De. Grace. Md. R?.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowned
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in water from capsized boat
20c. TIME OF INJURY: Hour 11 a.m. p.m. Month, Day, Year 6 20 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Susquehannah River
20f. (City or town) Havre Degrace (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): R.C.Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-23-60

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 6/26/60
22c. NAME OF CEMETERY OR CREMATORY: Angel Hill
22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: [redacted] Havre de Grace, Md
24a. REC'D BY REGISTRAR DATE: JUN 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6817

CERTIFICATE OF DEATH

06790

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2/ Elkton
d. STREET ADDRESS: 1/ 402 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rodney Middle H. Last DANN 3rd

4. DATE OF DEATH: Month June Day 14 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 12, 1960
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 2
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rodney Dann
14. MOTHER'S MAIDEN NAME: Hester J.Walton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT Address: Rodney Dann 402 Maryland Ave.,Elkton,Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity 1lb 11ozs.
774X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Placental Insufficiency (Maternal)
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 JUNE, 1960, to 14 JUNE, 1960 that I last saw the deceased alive on 14 JUNE, 1960, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George J Kreis, Jr M.D.
ADDRESS (Street, city or town, state): 2012 Main St. Elkton Md
DATE SIGNED: 6/16/60
PHYSICIAN'S NAME (Type): George J.Kreis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 16,1960
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cem.
22d. LOCATION (City, town, or county) (State): Newark,Del.

23. FUNERAL DIRECTOR'S SIGNATURE: R.T. Jones
ADDRESS: Newark, Del.
24a. REC'D BY REGISTRAR DATE JUN 21 '60
24b. REGISTRAR'S SIGNATURE: Cathryn S Krauss

2065231 XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6834

CERTIFICATE OF DEATH

0679

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Warwick Md.
c. LENGTH OF STAY IN 1b: 75Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Middletown Del. Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Louise — Middle — Last Degnan

4. DATE OF DEATH: Month 6/29/60 — Day — Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept.25th, 1875

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cecilton Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Boyles

14. MOTHER'S MAIDEN NAME: Anna Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs Ritchard Aiken Middletown Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebro-Vascular accident — 6 days.

DUE TO (c): Cerebral arteriosclerosis — years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous CVA with partial paralysis -3 years. senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1 19 57, to June 29th, 19 60, that I last saw the deceased alive on 6/29/60, 19, and that death occurred at 310 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace G. Obenshain M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 6.30.60

PHYSICIAN'S NAME (Type): Wallace G. Obenshain, M.D. — Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/2/60

22c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cemetery

22d. LOCATION (City, town, or county) (State): Warwick Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Middletown Del.

24a. REC'D BY REGISTRAR DATE: JUL 5 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6813 — 06752 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shamokin
d. STREET ADDRESS: 226 Thorp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Albert Middle Last Duncheskie — Arthur
4. DATE OF DEATH: Month 6 Day 11 Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-4-1898
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plummer
10b. KIND OF BUSINESS OR INDUSTRY: Plumming
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jesse Duncheskie
14. MOTHER'S MAIDEN NAME: Anna Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) Yes — (If yes, give war or dates of service) WW # 1
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs. Arthur A. Suncheskie, Shamokin, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Drowned — INTERVAL BETWEEN ONSET AND DEATH
850X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell out of boat in Elk River
20c. TIME OF INJURY: Hour 8 a.m. p.m. — Month, Day, Year: 6 11 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Elk River
20f. (City or town) (County) (State): Elkton, R.D. Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐ Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): R.C.Dodson
DEPUTY MEDICAL EXAMINER ☒ 6-12-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/15/60
22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows
22d. LOCATION (City, town, or county) (State): Coal Twp. Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR — DATE: JUN 16 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Preuss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 6835 (6793) 96

1. PLACE OF DEATH
a. COUNTY Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.
c. LENGTH OF STAY IN 1b: 3 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Washington, D.C. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Of Columbia
d. STREET ADDRESS 226-5th St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle Last EDGE
4. DATE OF DEATH: Month 6- Day 18 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-14-91
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Lawrence, Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH EDGE
14. MOTHER'S MAIDEN NAME: MARY A. HADFIELD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Beatrice Edge (Wife) Address 226-5th St., S.E. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION BY FOOD — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
921.7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PSYCHOSIS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Savaging Food At Noon Meal
20c. TIME OF INJURY: Hour 12:15 p. m. Month, Day, Year 6-18 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) (County) (State): VAH, Perry Point, Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R.C. Dodson M.D.
EXAMINER'S NAME (Type) R.C. DODSON, M.D.,
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 6-18-60

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 6/22/1960
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Pennington & Son, Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE JUN 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registration number, or removal

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6819

Reg. Dist. No. 0679

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RISING SUN RURAL
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROSA Middle LONGACRE Last FELL

4. DATE OF DEATH: Month 6/ Day 18/ Year 19 60

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/ 30/ 1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): PENN.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELWOOD LONGACRE

14. MOTHER'S MAIDEN NAME: RACHEL FRICKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 217-36-2558

17. INFORMANT: NORMAN J. FELL Address: NOTTINGHAM PENN.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO (b): Extensive Abdominal Carcinomatosis — 6 mos.
DUE TO (c): Ovarian Carcinoma — 4 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 22, 19 58, to 18 June, 19 60, that I last saw the deceased alive on 18 June, 19 60, and that death occurred at 1:30p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D.
ADDRESS (Street, city or town, state): Cecilton, Md.
DATE SIGNED: 20 June 60

PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/21/1960
22c. NAME OF CEMETERY OR CREMATORY: ROSE BANK CEM.
22d. LOCATION (City, town, or county) (State): CALVERT MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hutton
ADDRESS: RISING SUN, MD

24a. REC'D BY REGISTRAR DATE: JUN 22 '60

24b. REGISTRAR'S SIGNATURE: William L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item Id, Film 625? 7/13/00 iwk

CERTIFICATE OF DEATH

6820

Reg. Dist. No. 06795

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pvt. home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 110 West Main St, Elkton,
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Isaac — Middle V. — Last Hammond

4. DATE OF DEATH: Month 6 — Day 29 — Year 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/19/1898

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dyer

10b. KIND OF BUSINESS OR INDUSTRY: Baldwin Mfg Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel V. Hammond

14 MOTHER'S MAIDEN NAME: Unkn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-01-1522

17. INFORMANT: Edward J. Hamm[illegible] Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic bronchitis and pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from June 24, 19 60, to June 29, 19 60, that I last saw the deceased alive on June 29, 19 60, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street
DATE SIGNED: 6/30/60

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr. Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/4/60
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cherry Hill Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter Lee Booth
ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JUL 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hamm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6836

CERTIFICATE OF DEATH

0079

1 PLACE OF DEATH
a. COUNTY CECIL
MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE District Of Co COUNTY

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point, Maryland

c. LENGTH OF STAY IN 1b
10Yrs,7Mon.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D.C.

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital

d STREET ADDRESS
3823 Mass. Ave., N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: HARRY Middle: ROSENBERG Last: HARRIS

4. DATE OF DEATH Month: 6 Day: 4 Year: 1960

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-20-02

9 AGE (In years last birthday): 58 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or period of service): WW-II

16 SOCIAL SECURITY NO: Unknown

17. INFORMANT: Mr. Lester Rosenberg(Brother) Address: 3823 Mass.Ave, NW, Wash.,D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA,RT. LUNG- UNRESOLVED — INTERVAL BETWEEN ONSET AND DEATH: 3 To 5 Dys.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) CARDIAC ARREST

DUE TO (c) CLOSURE OF EVISCERATION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized, moderately severe

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that ☒ (this hospital) attended the deceased from 10-24- 19 49 to 6-4- 19 60 that I (have) last saw the deceased alive on XXXXXXXXXXXXXXXXXXXXXXXXXXXX, and that death occurred at 4:30 AM from the causes and on the date stated above

22a SIGNATURE: F. L. Garey M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 6-6-60

22c. PHYSICIAN'S NAME (Type): J. L. GAREY, M. D.

22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify) Burial 6/8/1960

23b. DATE THEREOF

23c NAME OF CEMETERY OR CREMATORY: Arlington Nat.

23d LOCATION (City, town, or county) (State): Ft. Myer Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Jennings & Son, Hyattsville Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE JUN 8 '60

25b. REGISTRAR'S SIGNATURE: Calvin L. Kuna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be handled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6821

Reg. Dist. No. 0679

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Earleville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First David — Middle Parker — Last Husfelt

4. DATE OF DEATH: Month June — Day 9, — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: October 6, 1881

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Cecilton, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Husfelt

14. MOTHER'S MAIDEN NAME: Martha Tims

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-36-7912

17. INFORMANT Address: Winnie Davis Husfelt, Earleville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Renal failure — 3 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Complete common duct obstruction, Prob. Ca of Pancreas mos. 1 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 May 60, 19__, to 9 June 60, 19__, that I last saw the deceased alive on 9 June 60, 19__, and that death occurred at 5:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 11 June 60

PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 13, 1960

22c. NAME OF CEMETERY OR CREMATORY: Cecilton Cemetery

22d. LOCATION (City, town, or county) (State): Cecilton, Cecil Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Edward Hellings, Millington, Md.

24a. REC'D BY REGISTRAR DATE: JUN 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06795

Reg. Dist. No. 6822

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hacks Point
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beverly — Middle: Ann — Last: Jones
4. DATE OF DEATH: Month: 6 — Day: 19 — Year: 19 60

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-5-40
9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary in Health Dept.
10b. KIND OF BUSINESS OR INDUSTRY: Clerkical
11. BIRTHPLACE (State or foreign country): Elkton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Woodrow Wilson Lunn
14. MOTHER'S MAIDEN NAME: Leona Pearce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-38-9951
17. INFORMANT: David Jones, Earville, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed chest fracture and laceratioj of skull
DUE TO (b): Lacerated right index and middle finger
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Car ran off road and turned over on her body
20c. TIME OF INJURY: Hour: 2.20 o. m. — Month, Day, Year: 6 19 60
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): County Road
20f. (City or town) Hacks Point (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-19-60
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 21, 1960
22c. NAME OF CEMETERY OR CREMATORY: Johntown Cemetery
22d. LOCATION (City, town, or county): Earleville, Rural (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fillows — ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR DATE: JUN 27 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6837

CERTIFICATE OF DEATH

0679

1. PLACE OF DEATH
a. COUNTY CECIL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT, MARYLAND
c. LENGTH OF STAY IN 1b 30 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA HOSPITAL, PERRY POINT, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a. STATE PENNSYLVANIA b. COUNTY CHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD
d. STREET ADDRESS 131 LANCASTER AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle W Last JONES
4. DATE OF DEATH Month 6 Day 3 Year 1960
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-9-90
9. AGE (In years last birthday) 89 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor-Supervisor
10b. KIND OF BUSINESS OR INDUSTRY Gon't
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WILLIAM W. JONES (Deceased)
14. MOTHER'S MAIDEN NAME JANE JOHNSON (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW-1
16. SOCIAL SECURITY NO. 195-05-9102
17. INFORMANT Mr.James McCrabb (Friend) Address: 133 Lancaster Ave., Oxford, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrage-Massive- Gastro-Intestinal Tract — INTERVAL BETWEEN ONSET AND DEATH 48 Hours
1.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Esophageal Varices
DUE TO (c) Cirrhosis Of Liver With Hepatoma, Diffuse

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, Generalized
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-4- 1960 to 6-3- 1960, that (I) (we) last saw the deceased on 6-3- 1960, and that death occurred at 10:?M, from the causes and on the date stated above.

22a. SIGNATURE James L Garey M D
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) JAMES L. GAREY, M.D.
22d. ADDRESS VA HOSPITAL, PERRY POINT, MARYLAND

23a. BURIAL CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF June 8.. 1960
23c. NAME OF CEMETERY OR CREMATORY Oxford Cem'y
23d. LOCATION (City, town, or county) (State) Oxford, Chester Co Pa.
24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Lee A. Patterson & Son, Perryville Md.
25a. REC'D BY REGISTRAR DATE JUN 9 '60
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6833 — Reg. Dist. No. 1168, 9

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2 mo. 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pri. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxen Hill
d. STREET ADDRESS: 4610 Cedar Ridge Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSEPH — Middle: G. — Last: KOLKEDY
4. DATE OF DEATH: Month: June — Day: 7 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-29-19
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Electrical
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Kolkedy
14. MOTHER'S MAIDEN NAME: Anna Mote

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Dorothy Kolkedy, wife — Address: Oxen Hill, Md. 4610 Cedar Ridge Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Strangulation by hanging — INTERVAL BETWEEN ONSET AND DEATH:
I 14 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-7-60
EXAMINER'S NAME (Type): R. C. DODSON

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 6/9/1960
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Pennington & Son, Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: JUN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06806

6839

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: Less than 24 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Abingdon
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ALBERT Middle VINCENT Last KUHN

4. DATE OF DEATH: Month June Day 23 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/10/13

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proprietor, Self employed

10b. KIND OF BUSINESS OR INDUSTRY: Lunch Room

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Kuhn (Deceased)

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 176-07-2681 ~~Unknown~~

17. INFORMANT: Kate Kuhn (Wife) Address: Abingdon, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intraventricular hemorrhage, bilateral, spontaneous — INTERVAL BETWEEN ONSET AND DEATH

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis with hypertension

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type): R. C. DODSON

DATE SIGNED: 6/24/60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: June 26, 1960

22c. NAME OF CEMETERY OR CREMATORY: Cokesbury

22d. LOCATION (City, town, or county) (State): Abingdon, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Howard K. McComas & Sons, Abingdon, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krouse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6823

CERTIFICATE OF DEATH

Reg. Dist. No. 06817

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 59
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 504 Bow St

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Elkton Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ?/ Elkton
d. STREET ADDRESS: 504 Bow St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: May — Last: Maloney
4. DATE OF DEATH: Month: June — Day: 13 — Year: 1960

5. SEX: F
6. COLOR OR RACE: Caus
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 30, 1901
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas P. McCall
14. MOTHER'S MAIDEN NAME: Fannie Folk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-4765
INFORMANT: Joseph F McCall — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive Heart Failure	48 hrs.
DUE TO (b)	Anemia & Malnutrition	3 mos
DUE TO (c)	Cancer of Ovary	6 Mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a m p m, 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 8, 1960, to June 13, 1960, that I last saw the deceased alive on June 13, 1960, and that death occurred at 8:30 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Joseph F. Lanzi, M.D. — ADDRESS (Street, city or town, state): 205 W Main st Elkton Md — DATE SIGNED: 6/13/60

PHYSICIAN'S NAME (Type): Joseph F. Lanzi, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county)	(State)
Burial	6/16/60	Bethel Cem.	Bethel	Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H Walter Dare Bose, Jr. — ADDRESS: Elkton, Md

24a REC'D BY REGISTRAR DATE: JUN 20 '60 — 24b. REGISTRAR'S SIGNATURE: Catherine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6824 — Reg Dist. No. 06803

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
d. STREET ADDRESS: Rd #4 Elkton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Mary — Middle: N. — Last: Marlow

4. DATE OF DEATH: Month: June — Day: 3 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 27, 1885

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Northington

14. MOTHER'S MAIDEN NAME: Maria Allen

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

INFORMANT: C.W. Marlow Jr (Son) — Address: Wilmington, Dela.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 hours
DUE TO (b): Arteriosclerotic Heartdisease — Years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic cholecystitis and cholelithiasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 1960, to June 3, 1960 that I last saw the deceased alive on June 3, 1960 and that death occurred at 4:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Tillman D Johnson M.D. — ADDRESS (Street, city or town, state): 123 Singerly Ave — DATE SIGNED:

PHYSICIAN'S NAME (Type): Tillman D. Johnson — Elkton, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: June 5, 1960

22c NAME OF CEMETERY OR CREMATORY: Lilpin Manor Memorial Park

22d. LOCATION (City, town, or county) (State): Elkton Maryland

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph E. Hicks, Elkton, Md.

24a. REC'D BY REGISTRAR — DATE: JUN 10 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Knull

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6825

CERTIFICATE OF DEATH

Reg. Dist. No. 0681 4

1 PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Bridge Street,

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton
d. STREET ADDRESS 113 Bridge Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First VERNON Middle H. Last McKNIGHT
4. DATE OF DEATH Month June Day 5, Year 1960

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 29, 1885
9. AGE (In years last birthday) 74 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give k'nd of work done during most of working life, even if retired) Medical Doctor
10b. KIND OF BUSINESS OR INDUSTRY Medicine
11. BIRTHPLACE (State or foreign country) Elkton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME A. Franklin Mc Knight
14. MOTHER'S MAIDEN NAME Anna Louise Janney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
INFORMANT Address Mrs. Adelia M. Mc Knight, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Immediate
DUE TO (b) Arteriosclerotic Heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 1960, to June 5, 1960 that I last saw the deceased alive on May 28, 1960, and that death occurred at 3:17 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Tillman D. Johnson M.D. ADDRESS (Street, city or town, state) 123 Singerly Ave DATE SIGNED
PHYSICIAN'S NAME (Type) Tillman D. Johnson Elkton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6-9-60
22c NAME OF CEMETERY OR CREMATORY Elkton Cemetery
22d. LOCATION (City, town, or county) Elkton, (State) Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Dee Elkton, Md.
24a. REC'D BY REGISTRAR DATE JUN 10 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6825 — Reg. Dist. No. 0681

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.D.5
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: K. — Last: Osborn
4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9-21-1940
9. AGE (In years last birthday): 19 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Hemlock, N.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Smith Osborne
14. MOTHER'S MAIDEN NAME: Pear Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-38-0821
17. INFORMANT: Smith Osborne — Address: Elkton, R.D.5. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subdural Hemmorrhage Cerebral laceration — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Contusion of brain Fractured ribs right
DUE TO (c): side posteriorly

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Car ran off road and into creek
20c. TIME OF INJURY: Hour 4.40 p. m. — Month, Day, Year: 6 11 19 60
20d. INJURY OCCURRED While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 273
20f. (City or town) (County) (State): Near Calvert Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X] and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 6-12-60
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-15-60
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.
22d. LOCATION (City, town, or county) (State): nr. Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: PIPPIN FUNERAL HOME Donald M. Pippin Elkton, Md.
24a. REC'D BY REGISTRAR: DATE JUN 16 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Knaus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6840 06862

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Charlestown
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR — Middle (NMI) — Last PAULSON

4. DATE OF DEATH: Month June — Day 2 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-15-87

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer (Retired)

10b KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Paulson (deceased)

14. MOTHER'S MAIDEN NAME: Lilly Stevenson (deceased)

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO: unknown

17. INFORMANT — Address: Mrs. Arthur Paulson, wife, Charlestown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b) Arteriosclerotic heart disease — unknown
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (X (this hospital) attended the deceased from May 18 1960, to June 2 1960 xxxxxxxxxxxx saw the deceased alive on xxxxxxxxxxxxxxxxxxxxxxxx and that death occurred at 2:50am from the causes and on the date stated above

22a. SIGNATURE: J. L. Garey M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6-2-60

22c PHYSICIAN'S NAME (Type): J. L. GAREY, Clinical Pathologist, V.A.Hospital, Perry Point, Md.
22d. ADDRESS

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-4-1960
23c NAME OF CEMETERY OR CREMATORY: Mt. Moriah
23d LOCATION (City, town, or county) (State): Philadelphia, Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant
ADDRESS: Joseph R. Grant, Northeast, Maryland

25a REC'D BY REGISTRAR DATE JUN 6 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6841 Items 3, 15 & 17, Film G-264 6/15/60.cac.

Reg. Dist. No. 06867

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page [redacted] may be retained for your [redacted] or to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5) 5M 9/55

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND — Items 8,9 # 265, 6/24/60 e
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: Sherwood — Last: PEARCE
4. DATE OF DEATH: Month: 6 — Day: 9 — Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-6-1889
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Jackson Pearce
14. MOTHER'S MAIDEN NAME: Mary Hoover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-36-1528
17. INFORMANT — Address: Mrs. Andrew S. Pearce, Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shot Gun wound of the head — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with shot gun in the mouth
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: 6 9 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chicken House
20f. (City or town): Cecilton (County): Cecil (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R C Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-9-60
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/12/60
22c. NAME OF CEMETERY OR CREMATORY: BETHEL CEM.
22d. LOCATION (City, town, or county) (State): CHESAPEAKE CITY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR DATE: JUN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Preas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06863

6842

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md.
c. LENGTH OF STAY IN 1b: 2mos 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Pennsylvania b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. STREET ADDRESS: 1220 Foulkrod St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Randi Middle: E. Last: Peterson
4. DATE OF DEATH: Month: 6 Day: 18 Year: 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-27-24
9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Phila., Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Olaff Peterson
14. MOTHER'S MAIDEN NAME: Verna Husted

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): PL-28
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Verna Peterson (M) Address: 1220 Foulkrod St. Phila. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Strangulation by hanging — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hanging by Pajama belt to nail in a door
20c. TIME OF INJURY Hour: 3:00 p. m. Month, Day, Year: 6-18- 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital, VA
20f. (City or town) (County) (State): Perry Point, Cecil, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-18-60
EXAMINER'S NAME (Type): R. C. DODSON, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): X
22b. DATE THEREOF: 6/19/60 6/23/60
22c. NAME OF CEMETERY OR CREMATORY: Beverly National Cem.
22d. LOCATION (City, town, or county) (State): Beverly N. J.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. Madison Mitchell Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: JUN 22 '60
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6843

Reg. Dist. No. 06809

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earleville
c. LENGTH OF STAY IN 1b: Home
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earleville X
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle — Last Rehfuss
4. DATE OF DEATH: Month June — Day 17, — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 15,1869
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lithograph
10b. KIND OF BUSINESS OR INDUSTRY: Lithpgraph
11. BIRTHPLACE (State or foreign country): Phila. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A. Rehfuss
14. MOTHER'S MAIDEN NAME: Mary Schwalder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mrs. Agnes Rehfuss, Earleville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 15 min
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease. — years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 17 May, 1960, to 17 June, 1960, that I last saw the deceased alive on 17 June, 1960, and that death occurred at 6:7 M, from the causes and on the date stated above

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md — DATE SIGNED: 19 June 60

PHYSICIAN'S NAME (Type): Wallace Obenshain — Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 20,1960
22c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cemetery
22d LOCATION (City, town, or county) (State): Warwick, Cecil Co; Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Wilmington, Del
24a. REC'D BY REGISTRAR DATE: JUN 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6844

CERTIFICATE OF DEATH

068(1)

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton (Rural)
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton, R.D.
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: K — Last: Sprout

4. DATE OF DEATH: Month: June — Day: 3 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 22, 1882

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paper maker, ret.

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Sprout

14. MOTHER'S MAIDEN NAME: Emma Jane Barrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-0804

INFORMANT: George Sprout, Elkton, R.D., Maryland.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Cancer of prostate gland. — 5 years

DUE TO

(c): — 0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ——, 19 55, to 6-3, 19 60, that I last saw the deceased alive on 6-3, 19 60, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 6-5-60

PHYSICIAN'S NAME (Type): PETER STAVRAKIS M.D. — Elkton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-7-60

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Mthodist Cem.

22d. LOCATION (City, town, or county) (State): Elkton, R.D., Cecil Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph A. Grant — ADDRESS: North East, Maryland.

24a. REC'D BY REGISTRAR DATE: JUN 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6827 **CERTIFICATE OF DEATH** 0681 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 6 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RISING SUN — RURAL
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GUSTAVE — Middle FERDINAND — Last WACHOWSKI

4. DATE OF DEATH: Month 6/ — Day 16/ — Year 19 60

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/ 29/ 1898

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM WACHOWSKI

14. MOTHER'S MAIDEN NAME: AUGUSTA NAUJOK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 096-05-0035

17. INFORMANT: MRS. MINNIE WACHOWSKI — Address: RISING SUN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left cerebral thrombosis with rt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

DUE TO (b): Cerebral arteriosclerosis — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year — 19 .

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) — (County) — (State)

21. I certify that I attended the deceased from 5/3, 1960, to 6/16, 1960, that I last saw the deceased alive on 6/16, 1960, and that death occurred at 11:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East, Md — DATE SIGNED: 16 June '60

PHYSICIAN'S NAME (Type): Klaus H. Huebner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 6/19/ 1960 — 22c. NAME OF CEMETERY OR CREMATORY: EBENEZER CEM. — 22d. LOCATION (City, town, or county) (State): RISING SUN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen — ADDRESS: RISING SUN, MD.

24a. REC'D BY REGISTRAR — DATE: JUN 20 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A1S (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06812

1. PLACE OF DEATH — a. COUNTY: Cecil — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton — c. LENGTH OF STAY IN 1b: MARYLAND hours — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Elkton, Jail

6823

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Baltimore — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3 Mo. — d. STREET ADDRESS: 116 W. Lee St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Millard	Franklin	Waddell	6.	20	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
M	W.		8-31-1910	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Building	Kenticky	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alfred Waddell	Learl Bruce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		Mrs. Millard F. Waddell. 116 W. Lee St.	Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of Brain and Fatty nutriccinal Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH

581.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE R.C. Dodson M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 6-21-60

EXAMINER'S NAME (Type) R.C. Dodson

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	6/25/1960	Buckeye Cemetery	Scioto Co. Ohio

23. FUNERAL DIRECTOR — ADDRESS: John M. Hiler & Sons, Inc. 401 S. Chester St. Baltimore Md. — 24a. REC'D BY REGISTRAR DATE: June 7, 1960 — 24b. REG STRAR'S SIGNATURE: Arthur L. Evans

TO DEPUTY [redacted]: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [redacted] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Replacement cert. 9/6/50 : Film fr. 270 - MB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6829

Reg. Dist. No. 06813

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 24 Kent Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle RACHAEL Last WALLACE

4. DATE OF DEATH: Month June Day 4, Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 23, 1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elkton, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lang

14. MOTHER'S MAIDEN NAME: Elizabeth Windels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

INFORMANT Address: Mrs. Catherine Cespades, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Parkinson's Disease — INTERVAL BETWEEN ONSET AND DEATH: several yrs.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic cardiovascular disease — unknown

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 1960, to June 4, 1960, that I last saw the deceased alive on June 3, 1960, and that death occurred at 1:15 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.

ADDRESS (Street, city or town, state): 233 E. Main Street

DATE SIGNED: 6/4/60

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR., M.D. Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 7, 1960

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: PIPPIN FUNERAL HOME Lonald Pippin Elkton, Md.

24a. REC'D BY REGISTRAR: JUN 10 '60

24b. REGISTRAR'S SIGNATURE: Clinton L. Mumma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06814

6830

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural North East
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

065

3. NAME OF DECEASED (Type or print): First Edna — Middle Dunlap — Last Wheatley

4. DATE OF DEATH: Month 6 — Day 8 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-10-1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOseph Chamberlin

14. MOTHER'S MAIDEN NAME: Gertrude Staley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-20-7194

INFORMANT: Dorothy Eveland Address: North East, Md. Route 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left cerebral thrombosis with rt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular Renal Disease — Tyrs

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) (County) (State): —

21. I certify that I attended the deceased from 4 June, 1960 to 8 June, 1960 that I last saw the deceased alive on 8 June, 1960, and that death occurred at 4:40 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D.

ADDRESS (Street, city or town, state): North East, Md.

DATE SIGNED: 6/8/60

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-11-60

22c. NAME OF CEMETERY OR CREMATORY: Greensboro

22d. LOCATION (City, town, or county) (State): Greensboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Brulais Greensboro, Md.

ADDRESS

24a. REC'D BY REGISTRAR DATE: JUN 13 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G265 6/29/60 iwk

6845

CERTIFICATE OF DEATH

Reg. Dist. No. 06815 97

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 7 hr. 35 Min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Station Hospital, USNTC, Bainbridge, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Port Deposit
d. STREET ADDRESS: 239 C Laffey Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cynthia; Middle: Lynne; Last: Willix

4. DATE OF DEATH: Month: June; Day: 24; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 24 June 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours: 7; Min.: 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Robert Graham Willix

14. MOTHER'S MAIDEN NAME: Enid Arlene Duston (Arlene Dusting)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANOXIA
762.0
DUE TO (b): CONGENITAL ATELECTASIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 7 hr. 35 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 June, 1960, to 24 June, 1960, that I last saw the deceased alive on 24 June, 1960, and that death occurred at 2334P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. A. Riggs M.D. — ADDRESS (Street, city or town, state): Station Hospital, USNTC, Bainbridge, Md — DATE SIGNED: 6/27/60

PHYSICIAN'S NAME (Type): W. A. RIGGS, LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 27 June 1960

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cemetery

22d. LOCATION (City, town, or county) (State): Colora, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson — ADDRESS: Lon, Perryville, Md

24a. REC'D BY REGISTRAR DATE: JUN 28 '60

24b. REGISTRAR'S SIGNATURE: Dallas S Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director. page 3 [illegible]ld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

Noon

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